

**ERIE COUNTY DEPARTMENT OF MENTAL HEALTH  
CONSUMER DISCHARGE SUMMARY**

Client Name:  
Social Security #:  
Program:  
Admission Date:  
AXIS I Diagnosis:  
AXIS II Diagnosis:  
Discharge Date:  
Discharge Site/Address:  
Reason for Discharge:

**DISCHARGE PLANNING**

**INSTRUCTIONS:** *The following checklist is to be completed by the Rehabilitation Counselor and submitted to the Client Caseworker two weeks prior to discharge. Please complete the form in its entirety. If all information is not available at the time of submission, indicate what information is known. If not applicable, indicate. This checklist will ensure a successful discharge is planned for our consumers.*

1. Date 30-day notice submitted:
2. Discharge site/address:
3. Is the discharge a:     ☐ Self           ☐ Agency     ☐ Jointly Planned
4. Was client linked with Section 8?     ☐ Yes ☐ No
5. If discharging to an independent setting:  
    Are the expenses affordable for the individual?     ☐ Yes           ☐ No  
    Joint meeting with Client and STEL scheduled?     ☐ Yes ☐ No  
    Security deposit returned?                             ☐ Yes           ☐ No
6. Has the individual been given emergency numbers/contacts (i.e.; Crisis Line, Hospital, Fire, Police)?     ☐ Yes           ☐ No
7. Does the individual have a balance with STEL, Inc.?     ☐ Yes           ☐ No
8. If yes, is there a payment plan in place?                             ☐ Yes           ☐ No
9. Financial Supports/Benefits  
    ☐ SSI ☐ SSD ☐ Public Assistance ☐ Medicaid ☐ Medicare ☐ Food Stamps  
    ☐ V.A. ☐ Employment ☐ Other:
10. Identified Payee:  
    Address:
11. Any other linkages? (Check all that apply)  
    ☐ Home Inc.           ☐ Staff Builders           ☐ Meals on Wheels           ☐ ACT  
    ☐ Compeer           ☐ Workforce           ☐ ICM           ☐ Other:
12. Medication Management:     Independent ☐ Yes ☐ No  
    Need Assistance     ☐ Yes ☐ No  
  
    If needs assistance, what supports/linkages have been made: (Check all that apply)  
    ☐ Staff Builders/VNA     ☐ Treatment (i.e.: ACT, Therapist, Case Manager)  
    ☐ Family/Friend

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13. Any at risk behaviors? (Check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Pedophilia/Child Molestation | <input type="checkbox"/> Hx of Suicidal/Homicidal Behaviors    |
| <input type="checkbox"/> Alcohol/Drug Use             | <input type="checkbox"/> Hx of Assaultive/Aggressive Behaviors |
| <input type="checkbox"/> Isolation                    | <input type="checkbox"/> Fire/Arson                            |
| <input type="checkbox"/> Legal Issues                 |  |

14. Treatment Recommendations/concerns:

15. Has therapist been notified regarding pending discharge (with consent)? ☐ Yes ☐ No

Recommendations/Concerns:

16. Skill Level: Any Significant deficiencies that might prohibit a successful discharge?

☐ Yes ☐ No

Indicate:

17. Any other pertinent information:

Indicate:

18. Recommended follow-along Services: ☐ 30-day ☐ 60-day

19. Has the landlord been notified? ☐ Yes ☐ No

20. Has a joint walk-through of the apartment been scheduled with client, staff and landlord?  
☐ Yes ☐ No

21. Has Section 8 been notified? ☐ Yes ☐ No

22. Is there a security deposit to be returned by landlord? ☐ Yes ☐ No Amount:

23. Date security deposit expected:

24. Has accounting been notified to stop stipend? (Rental stipend change form) ☐ Yes  
☐ No

Signature: \_\_\_\_\_

Print Name and Title: